



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW LICENSE APPLICATION
CHIROPRACTIC

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at **1-877-672-2174**, Monday through Friday, 8AM to 5PM EST. **A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

Section 1B. BASIS OF APPLICATION

Check the box next to the type of license for which you are applying. Chiropractors who are applying for Non-Invasive Ancillary Procedures and a Chiropractor's license must pay a total of \$572.00

CH - Chiropractic	\$416.00
CH - Chiropractic Non-Invasive Ancillary Procedures	\$208.00
CH / ANC - Chiropractic License with Ancillary Procedures	\$624.00
Ancillary Re-exam	\$91.00
Chiropractic Re-exam	\$260.00

Make check or money order payable to Promissor

Mail To:

Department of Health
Health Professional Liscencing Adminstration
717 14th Street, NW
Suite 600
Washington, DC 20005

Walk-in Service

Monday through Friday, 9 to 4 EST

717 14th Street, NW
Suite 600
Washington, DC 20005

Duplicate Licenses (limit 5) X \$26.00 \$

Total Enclosed \$

HPLA ONLY

Check \$

Check #

Staff

Section 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you attended college or university, please complete Section 4 on page 2. You must also provide legal name change document for EACH time thatit has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

First Name

Last Name

MI

Suffix (Jr, Sr, etc.)

Social Security Number

Date Of Birth (mm/dd/yyyy)

Place Of Birth

Male Female

Gender

Please Check the Correct Box

Section 3. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Section 4A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

Apartment Suite Floor PO Box Building Number

Street Address 1

Street Address 2

City

State Zip Code + 4

Phone Fax Email

Section 4B. BUSINESS ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

Company Name

Apartment Suite Floor PO Box

Building Number

Street Address 1

Street Address 2

City

State

Zip Code + 4

Phone

Fax

Email

Section 4C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed and will also be the address displayed on the website. The address that will appear on your license will be your business address.

Home Business

Section 5A. PROFESSIONAL SCHOOLS ATTENDED

List all professional schools that you have attended, in reverse chronological order, beginning with the most recent at the top.

[illegible]

Section 5B. MEDICAL/PROFESSIONAL TRAINING AND MEDICAL/PROFESSIONAL PRACTICE

List all experience since medical/professional school graduation below. Include letters from employing facilities and organizations for internships, residencies, fellowships or employment. For "Description", use the letter from the key below. List experience in reverse chronological order, beginning with the most recent.

[illegible]

* TRAINING AND PRACTICE DESCRIPTIONS

- A. Fellowship D. Apprenticeship G. Other (Attach a typed explanation on a separate sheet of paper to this form.)
B. Internship E. Employment
C. Residency F. Private Practice

Section 5C. MEDICAL/PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS

Are you now or have you ever been licensed in DC or any other state/jurisdiction?	Yes No
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(If "Yes", be sure to complete section 5C of this form.) You must request verification of licensure for all of these licenses, past and/or present.

[illegible]

Section 6. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included in this package or requested to be sent to the DC Board of Medicine. Keep a photocopy of all supporting documents for your records.

**HPLA
ONLY**

A.	Two recent passport-type photos of the applicant's face (approx. 2" X 2") with applicant's name printed on the back. Home snapshots or computer photographs are not acceptable.	Yes No	
B.	Three (3) characters reference forms.	Yes No	
C.	Verification(s) of licensure - These should be provided in a sealed envelope from the issuing jurisdiction for each license identified above in Section 5C on this page.	Yes No	
D.	All undergraduate, graduate, medical, and profession school transcripts. These transcripts should be provided in a sealed envelope from the issuing institution for each of the schools that you attended and listed in Section 5A on the previous page, except MD acupuncturists.	Yes No	
E.	Documentation of all experience following graduation from medical school. Proof of experience should be submitted as a letter from the overseeing institution/organization.	Yes No	
F.	Examination scores - These should be provided in a sealed envelope from the NBCE	Yes No	

Section 7. QUESTIONS**Applicants MUST answer all of the following questions**

Please answer questions A through K by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through K below, you must provide full information and complete details on a separate sheet of paper, including copies of all relevant court documents, and attach to this form.

A.	<p>Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.</p> <p>Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke the license or permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to DC Official Code § 47-2864 (2001).</p> <p>IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED.</p> <p>As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia government as a result of any of the following:</p> <p>Fines, penalties, or interest assessed pursuant to DC Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985) Fines or interest assessed pursuant to DC Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994) Fines, penalties, or interest assessed pursuant to DC Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985) Past due taxes Past due District of Columbia Water and Sewer Authority service fees Fines or penalties assessed pursuant to DC Official Code Title 50, Chapter 23 (Traffic Adjudication)</p> <p>The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the Clean Hands Before Receiving a License or Permit Act of 1996, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).</p>	Yes No	HPLA ONLY
B.	Have you ever been convicted of or investigated for a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	Yes No	
C.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	Yes No	
D.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	Yes No	

E.	Has any authority taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this board?	Yes No	
F.	Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?	Yes No	
G.	Have you ever been terminated from or resigned from a clinical or professional training program?	Yes No	
H.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	Yes No	
I.	Within the last ten (10) years, have you been treated for alcohol abuse, controlled substance abuse, prescribed medication abuse, or illegal drug abuse?	Yes No	
J.	(1) Have you withdrawn an application (in DC or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	Yes No	
K.	Have you ever been terminated due to practice issues or behavioral issues since obtaining your (professional) license within the last ten (10) years?	Yes No	

Section 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

APPLICANT SIGNATURE
NAME (please print)
DATE

HPLA ONLY

To report waste, fraud, or abuse by any DC government office or official, call the DC Inspector General at 1-(800)-521-1639.